Witness Statement Ref. No. 341/1

NAME OF CHILD: **Raychel Ferguson**

Name: Anthony Peter Walby

Title: Mr.

Present position and institution:

Retired

Previous position and institution:
[As at the time of the child's death]
Associate Medical Director; Litigation Management Office - Royal Group Hospital Trust ("RGHT").

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between November 1995-present]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

OFFICIAL USE:
List of previous statements, depositions and reports attached:

Ref:	Date:	

IMPORTANT INSTRUCTIONS FOR ANSWERING:
Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number. If the document does not have such a number then please provide a copy of the document.

(1) With respect to the death of Raychel Ferguson please advise:

(a) When you first received notification of her death and by what means;

The Litigation Management Office received a letter from HM Coroner dated 11th December 2001 on 17th December 2001 (064-042-131). I wrote to Dr. Crean to request a witness statement on 11th January 2002 (064-041-130). I therefore became aware of the death at sometime between 17th December 2001 and 11th January 2002 however there is no record of the date. I note that Dr. Carson in his witness statement WS-306/1, Page 3, 1e states that if HM Coroner was notified, it would be brought to my attention by the consultant or a senior member of the medical team involved, or by HM Coroner. I can state that notification to me (by a member of the medical team involved) that HM Coroner had been notified was not a routine Trust procedure although I occasionally may have been made aware that a case had been referred to the Coroner before the Coroner requested my assistance. For the avoidance of doubt, Dr. Crean or his team did not advise me of the death.

(b) What communications with the Altnagelvin Hospital were thereby provoked;

None. HM Coroner's letter of 11th December, 2001 indicated he already knew of Altnagelvin Hospital's involvement and only requested statements from those following transfer to Belfast (064-042-131).

(c) Whether you discussed the matter with Consultant Intensivists in PICU;

I do not believe I had any discussion with Dr. Crean prior to submitting his witness statement to the Coroner. When I was made aware that there had been a previous case of hyponatraemia (see 7 below) I asked Dr. Crean if he knew of it and he provided the name of Adam Stain (064-026-068) which I forwarded to Mr. Brangam (064-030-090 - 12/12/02, 064-027-069 - 16/12/02). I attended a pre-Inquest consultation which Mr. Brangam had with Dr. Crean in January 2003 (064-022-063). After speaking to Dr. Carson as requested by Mr. Brangam I spoke to Dr. Crean again on 21st January 2003. I do not recollect what the discussion with Dr. Carson or Dr. Crean was about. I did not attend a further pre-Inquest consultation between Dr. Crean and Mr. Brangam and I did not attend the Inquest. I did not have any other discussions with Consultant Intensivists in PICU.

(d) Whether the RBHSC was involved with the Altnagelvin Hospital Critical Incident Review into Raychel's care and treatment? If so please detail;

I am not aware of any involvement.

(e) Did you receive a report in writing into the case of Raychel Ferguson? If so please provide the same.

The only report I received into the case of Raychel Ferguson was Dr. Crean's witness statement (064-041-129) which is already in the possession of the Inquiry.

(2) Was Raychel Ferguson's case reported as an Adverse Incident within the RBHSC in accordance with the Policy TP9/00?

I do not know.

(3) Whether the details of Raychel Ferguson's case were communicated to the office of Associate Medical Director (Clinical Performance) in the RGHT?

There was no separate office of the Associate Medical Director in the RGHT. The Associate Medical Director worked in the Litigation Management Office. All details of Raychel Ferguson's case are contained in its Inquest file and Clinical Negligence file.

(4) Was there any discussion of, or reference to Raychel's case at any other meeting, whether Committee, Grand Round or Training? If so, please provide record thereof.

See Schedule RGH 20, Item 4 (063-037-095)

(5) Was there any reference to Raychel's case at Trust Board level or at other hospital committee meetings? If so, please provide record thereof.

I do not know.

(6) Did you keep a file or record of your work in relation to the case of Raychel Ferguson and did you retain all documentation relating thereto? If so please confirm that the Inquiry has been furnished with all such documentation.

The record of my work in relation to the case of Raychel Ferguson is contained in the Litigation Management Office Inquest file and Clinical Negligence file already furnished to the Inquiry.

(7) In relation to your letter to Mr. George Brangam dated 16th December 2002 (Ref: 064-027-069) *"The other case which has relevance was in 1995, Adam Strain... This will let us make preparations in anticipation of the Inquest"* please state how knowledge of the Adam Strain case permitted you to *"make preparations in anticipation of the Inquest"*?

I believe Mr. Brangam advised me verbally in mid-December 2002 (although it is unlikely to have been 'yesterday' which was a Sunday as per my letter) that he recollected a previous case involving hyponatraemia and Dr. Sumner where he had represented the Trust. This case had occurred before I was appointed to post. I asked Dr. Crean who was able to identify the case and I provided Mr. Brangam with the case references (064-027-069) in order that he could look them up in preparation for the Inquest. My use of the word "us" in my letter meant "you on behalf of the Trust".

(8) In relation to that letter addressed to you by Mr. George Brangam, dated 16th January 2003 (Ref: 064-022-063) and the statement *"Dr. Creane has indicated to me that the facts surrounding an earlier matter (Adam Strain Deceased) were not on all fours with the present case but, I believe, it would be prudent for you to speak directly with Dr. Ian Carson in relation to this matter, particularly, given it would appear that the Department has some knowledge of the circumstances surrounding this particular incident"* please state:

(a) The relevance, as at January 2003, of the *"facts surrounding an earlier matter (Adam Strain deceased)"* to the preparation for the Inquest into the death of Raychel Ferguson;

See 7 above. Both cases involved hyponatraemia. I did not provide direction to Mr. Brangam regarding his representation of the Trust at the Inquest.

(b) Whether you agreed in the circumstances it was prudent to speak directly with Dr. Ian Carson;

My handwritten note on the letter indicates I had already spoken to Dr. Carson by 20th January 2003 when I received Mr. Brangam's letter of 16th January 2003. I do not recollect any consideration of prudence. I was responding to Mr. Brangam's earlier verbal request.

(c) What information you obtained from Dr. Carson;

I do not recollect whether I obtained any information from Dr. Carson or whether I was to provide information the Trust had.

(d) What knowledge the Department had of the circumstances surrounding this particular incident (Adam Strain)?

I do not recollect the outcome of my discussion with Dr. Carson. This question could be answered by the Department.

(9) In relation to your letter to Mr. Brangam dated 26th January 2003 (Ref: 064-019-054) and the note *"I have spoken to Dr. Crean and he will stick to his brief at the Inquest and he is aware you will want to consult with him finally just before the hearing"* please advise:

(a) What was his *"brief"*;

The brief of a Trust medical or nursing witness at an Inquest is to provide their firsthand factual evidence. Mr. Brangam as the Trust's solicitor would normally advise witnesses of this and sometimes he would ask that I remind witnesses of their role.

(b) What did you mean by, and what were the implications of, the phrase *"stick to his brief"*?

I believe that Mr. Brangam will have asked me to remind Dr. Crean of his role as in 9a, and that as there would be an independent expert witness retained by the Coroner giving evidence that Dr. Crean should provide his firsthand factual evidence only and not give any expert witness evidence which he might think of spontaneously unless requested particularly to do so by the Coroner.

(10) In relation to Mr. Brangam's letter to you dated 31st January 2003 (Ref: 064-016-050) *"I cross-examined Dr. Sumner in relation to the Adam Strain case and I asked him to distinguish and differentiate between the two cases..."* please advise as to why it was felt necessary to distinguish and differentiate in this manner?

Mr. Brangam's letter dated 31st January 2003 must be wrongly dated as it is his report to the Trust following the first day of the Inquest hearing on 5th February 2003. I do not know what was in Mr. Brangam's mind. His representation of the RGH Trust was using his own professional skill and was not directed by me and I am unable to advise on how he chose to conduct his representation.

(11) In relation to your letter to Mr. George Brangam dated 17th February 2003 (Ref: 064-014-046) *"thank you very much for minding our back at this Inquest. Although my alarm bells proved to be ringing unnecessarily it was wiser to be prepared just in case"* please state:

(a) Why you were grateful in this instance that Mr. George Brangam should have represented the RGHT interests in the way that he did at the Inquest;

My letter was a general letter of thanks to Mr. Brangam for his provision of representation and not in relation to how he provided it. My initial plan had been that the Trust did not require legal representation at the Inquest (064-037-124), however the Coroner's office suggested it (064-038-125) and I complied.

(b) What the RGHT vulnerabilities to which you alluded were;

I was not alluding to vulnerabilities. I was replying to Mr. Brangam's letter of 5th February 2003 (wrongly dated 31st January, 2003). I was conceding that legal representation was appropriate in the circumstances whereas previously I had not thought it necessary.

(c) What the concerns that made your alarm bells ring were;

My only alarm bells were the concerns raised by Mr. Brangam that he considered it possible that the care and treatment given by the Trust could have been explored at the Inquest. Mr. Brangam iterated this in his report dated 20th February 2003 (064-004-027) on the remaining three days of the Inquest. He repeated his earlier view of 31st January 2003 that he believed it to be essential that a watching Brief had been retained and stated it was essential for the Trust to be represented.

(d) How the outcome of the Inquest proved that your alarm bells had rung unnecessarily;

No criticism arose of the Trust or its staff at the Inquest or in the Verdict.

(e) What was the possible case against which it was *"wiser to be prepared"*?

Mr. Brangam's concern as per 11c.

(12) In relation to the clinical negligence claim brought by the family of Raychel Ferguson against the RGHT please advise as to when this matter was resolved and by what means. If it is possible to forward a set of pleadings, please do so.

The RGH Trust clinical negligence file which is in the possession of the Inquiry contains a letter (065-013-027) dated 1st May 2003 from solicitors representing the parents of Raychel Ferguson. No proceedings were issued.

(13) Please provide such additional comment as you think appropriate. It would be of very considerable assistance if you could also attach any such further document that may be helpful.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: A.P. Walby **Dated:** 31st May 2013